

NOVA

MEDICAL & URGENT CARE CENTER

PATIENT INFORMATION			
NAME (FIRST, MIDDLE, LAST)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
PERMANENT ADDRESS (STREET & APARTMENT NUMBER)		TEMPORARY ADDRESS IF ANY (STREET & APARTMENT NUMBER)	
PERMANENT ADDRESS (CITY, STATE & ZIP)		TEMPORARY ADDRESS (CITY, STATE & ZIP)	
PERMANENT HOME PHONE NUMBER (INCLUDING AREA CODE)		TEMPORARY HOME PHONE NUMBER (INCLUDING AREA CODE)	
E-MAIL	AGE	NAME / ADDRESS FOR NON-CUSTODIAL PARENT	
WORK PHONE NUMBER	CELL PHONE	MINOR'S FATHER'S NAME / SOCIAL SECURITY / DATE OF BIRTH	
OCCUPATION		MINOR'S MOTHER'S NAME / SOCIAL SECURITY / DATE OF BIRTH	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		EMPLOYER	
EMERGENCY CONTACT	PHONE NUMBER	EMPLOYER ADDRESS	
HOW DID YOU LEARN ABOUT OUR PRACTICE? (BE SPECIFIC) NEWSPAPER _____ INTERNET _____ LOCAL EVENT _____ THEATER PHONE BOOK INSURANCE FRIEND OTHER _____			
INSURANCE INFORMATION			
NAME OF POLICY HOLDER (FIRST, MIDDLE, LAST)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
PERMANENT ADDRESS (STREET & APARTMENT NUMBER)		NAME OF INSURANCE (IF YOU HAVE THREE, LIST ALL)	
PERMANENT ADDRESS (CITY, STATE, ZIP)		1)	
		2)	
		3)	
PERMANENT HOME PHONE NUMBER (INCLUDING AREA CODE)		TYPE OF POLICY (HMO, PPO, STANDARD INDEMNITY)	PATIENT'S I.D. NUMBER
PATIENT RELATIONSHIP TO INSURED		1)	1)
CURRENT PRIMARY CARE PHYSICIAN (AS LISTED ON CARD)		2)	2)
EMPLOYER		3)	3)
EMPLOYER'S ADDRESS / PHONE NUMBER		GROUP NUMBER	
SPOUSE'S EMPLOYER / WORK PHONE NUMBER		1)	
NEAREST RELATIVE NOT LIVING WITH YOU		2)	
RELATIVE'S PHONE NUMBER (INCLUDING AREA CODE)		3)	

I certify that this information is true and correct to the best of my knowledge.

Signature of Person Financially Responsible

Date

Accepted By

AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use / disclosure of health information about me as described below.

Patient's Name: _____

Patient's Birth Date: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) of Organization(s) authorized to receive the information:

C. Specific description of the information that may be used or disclosed (including date(s)):

D. Specific description of how the information will be used:

1) I understand that this authorization **will expire** on _____.

2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying _____ in writing.

3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).

4) I may **inspect or copy** any information used or disclosed under this agreement.

5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

Patient's Signature or Patient's Representative

Date

Printed Name of Patients Representative

Relationship to Patient

NOTE:

- You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.")
- You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of health care provider(s)).
- You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Use / Disclosure of Protected Health Information
This form does not constitute legal advice and covers only federal, not state laws.